TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name_____Date:_____

Facility Type: _____ License #: _____ Telephone:_____

Address: _____Contact person(s):_____

Type of abortion that caused or may have caused the complication(s):_____

The number of weeks of gestation at which the abortion was performed:_____

Number of patient's previous induced abortions:_____ Number of patient's previous live births: _____

Type of anesthesia used during the procedure: ☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated <u>if different</u> than the above information:

Facility Name and Type: _____Date:_____

Complications Information (check all that apply):

- ☐ Incomplete Abortion
- ☐ Post-procedure infection
- ☐ Hemorrhage
- ☐ Damage to the uterus
- ☐ Death
- ☐ Other

Summary of abortion complication(s) :

_____
_____
_____
_____
_____

Within **<u>30 calendar days of the discovery of the complication</u>:**
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124